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Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

CIGNA HEALTHCARE OF CONNECTICUT, INC.,

Petitioner,

v.

ROBERT S. NAPOLETANO, ET AL. and
F. BARRETT HOLLIS, ET AL.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF CONNECTICUT

PETITION FOR WRIT OF CERTIORARI

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110 pp

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, preempts state law claims by participants of an employee welfare benefit plan to enforce the terms of the plan or remedy alleged misrepresentations about plan benefits.

2. Whether ERISA preempts state law causes of action for reinstatement and other relief asserted by physicians terminated from a network which provides services to ERISA plans.

PARTIES TO THE PROCEEDING

All parties to the proceedings below are parties before this Court. The petitioner is CIGNA HealthCare of Connecticut, Inc. The respondents are F. Barrett Hollis, Vinetta Hollis, Elaine Arnett, Ellen Gentile, Darlene Chiloyan, Margaret Cooper, Richard A. Johnson, Sharon W. Johnson, Don Ludwinowicz, Robert S. Napoletano, Jeffrey B. Steckler, Terrence K. Donahue, Robert Cosentino, Raphael Cooper, Paul Ceplenski, Ijaz Shafi, David Bass and David Belman.

Pursuant to Rule 29.6 of the Rules of this Court, petitioner CIGNA HealthCare of Connecticut, Inc. states that it is a wholly-owned subsidiary of CIGNA Health Corp., which is a wholly-owned subsidiary of Connecticut General Corporation, which is a wholly-owned subsidiary of CIGNA Corporation, a publicly held corporation. CIGNA HealthCare of Connecticut, Inc. has no subsidiaries.

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v.

ROBERT S. NAPOLETANO, ET AL. and
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Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF CONNECTICUT

PETITION FOR A WRIT OF CERTIORARI

CIGNA HealthCare of Connecticut, Inc. respectfully requests that a writ of certiorari be issued to review the judgment of the Supreme Court of Connecticut entered on July 23, 1996.

OPINIONS BELOW

The opinion of the Superior Court of Connecticut dated December 5, 1994 is not reported. (App. 45a.) The

opinion of the Supreme Court of Connecticut was issued on July 23, 1996 and is reported at 238 Conn. 216 and 680 A.2d 127. (App. 1a.) The orders of the Supreme Court of Connecticut denying the motions for reargument *en banc* are unreported. (App. 66a-67a.)

JURISDICTION

The Supreme Court of Connecticut entered its judgment in this case on July 23, 1996. (App. 1a.) Petitioner timely sought rehearing by that Court, and that request was denied on September 18, 1996. (App. 66a-67a.) This Court's jurisdiction to review the final judgment of the Supreme Court of Connecticut is invoked pursuant to 28 U.S.C. § 1257(a).

STATUTORY PROVISIONS INVOLVED

The statutory provisions involved are the Connecticut Unfair Trade Practices Act, Conn. Gen. Stat. § 42-110a, *et seq.* (1992 & Supp. 1996), the Connecticut Unfair Insurance Practices Act, Conn. Gen. Stat. § 38a-815, *et seq.* (1992 & Supp. 1996), the Connecticut Managed Care Act, Conn. Gen. Stat. § 19a-166b (Supp. 1996), and the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* The respective relevant provisions are set out at App. 68a-73a.

STATEMENT OF THE CASE

Petitioner CIGNA HealthCare of Connecticut, Inc. ("CHC") was at all relevant times a federally qualified and state authorized health maintenance organization ("HMO") that provides prepaid health care coverage to its subscribers through a network of selectively contracted medical providers. Petitioner directly contracts with physicians, hospitals, and others to obtain services for HMO subscribers at a discounted rate from normal charges. The size of the provider network is intentionally limited so that each provider can expect to receive a substantial patient volume from among HMO subscribers. This increased patient volume, in turn, provides an incentive to the network providers to discount their fees and to agree to participate in various quality and utilization management programs. Petitioner markets its HMO to employers sponsoring ERISA-covered employee welfare benefit plans that provide health care coverage to employees and their dependents.[1]

In August 1994, two separate law suits were filed in Connecticut Superior Court complaining of petitioner's conduct in managing its provider network. *Napoletano v. CIGNA HealthCare of Connecticut, Inc.* was brought by nine physicians who alleged that petitioner had removed them from the provider network in September 1993. The second

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[1] Similar networks are used to operate preferred provider organizations ("PPOs"). In PPOs, subscribers receive financial incentives to utilize network (preferred) providers, but may also seek care from non-preferred providers. The expectation is that most participants will choose to utilize the provider network, resulting in a greater volume of patients for these providers.

action, *Hollis v. CIGNA HealthCare of Connecticut, Inc.*, was brought by nine HMO subscribers -- patients of the *Napoletano* plaintiffs -- who had received health care under ERISA plans that used the CHC provider network. Both complaints asserted various state statutory and common law claims in connection with petitioner's removal of the nine physicians from its provider network.[2] As relief, both complaints sought, in addition to damages, injunctions reinstating the physicians in the network and thus requiring petitioner and the employee benefit plans that had contracted with petitioner to pay for services provided by these physicians.

In its December 1994 decision, the Superior Court granted petitioner's motion to strike all claims asserted in both actions as preempted by § 514 of ERISA, 29 U.S.C.

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[2] The *Napoletano* complaint alleged that petitioner breached its contract with the physicians by terminating them from the network "without just cause." The second and third counts alleged breach of an implied covenant of good faith and fair dealing and tortious interference with business expectancies in connection with the contract's termination. The complaint also contained claims that petitioner had violated both the Connecticut Unfair Trade Practices Act (by committing various acts of misrepresentation and false advertising in the course of engaging in the business of insurance) and the Connecticut Managed Care Act (by terminating the physicians without cause). The *Hollis* complaint also alleged that petitioner had violation the Connecticut Managed Care Act by terminating the physicians from the network without cause. In addition, it asserted that petitioner had committed violations of state statutory and common law by misrepresenting to its HMO subscribers the terms and conditions of the physicians' participation in the CHC provider network.

§ 1144. (App. 56a-64a.) Recognizing that the claims focused on the removal of the physicians from the network, the court held that they constituted "in essence, a complaint about plan administration [which] is a core ERISA concern." (App. 58a.) Accordingly, because the claims implicated plan administration (including seeking reinstatement of the physicians as eligible to provide services under ERISA plans), the court held that they necessarily "relate to" ERISA plans and were thus preempted.

On July 23, 1996, the Supreme Court of Connecticut reversed the trial court and reinstated all claims, holding that the preemptive effect of ERISA was limited "to state action that demonstrably burdens ERISA plans." (App. 29a, 39a.) Because the court found that the state law claims at issue "merely turn on requiring CIGNA to enforce the benefit plan that it has already established and is maintaining," but did not seek to modify those plans, the claims did not "relate to" the ERISA plans involved. (App. 34a-35a.) In so holding, the court interpreted this Court's recent decision in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995) ("*Travelers*") and subsequent lower court decisions as signaling a "retreat" from ERISA preemption. (App. 24a, 27a.) Based on this perceived trend and without analyzing the plain language of the preemption clause or attempting to distinguish a uniform body of contrary precedent, the court reversed the trial court's decision and remanded for further proceedings. On September 18, 1996, the state Supreme Court denied without opinion petitioner's motions for reargument. (App. 66a-67a.)

REASONS FOR GRANTING THE WRIT

Over 114 million Americans receive health care benefits through ERISA-covered employee welfare benefit plans, and a majority of them receive their care through provider networks such as the network at issue here. The questions presented here are therefore of great concern not only to petitioner, but to other entities that manage provider networks, to plan sponsors providing their employees with such coverage, and to physicians and other health care providers who offer an increasing percentage of their services through provider networks rather than through traditional fee-for-service arrangements. These questions are also of great interest to state officials attempting to regulate managed care practices in their jurisdictions who face continuing uncertainty as to whether such regulation is preempted by ERISA. Because of the importance of these questions, and because this decision conflicts with decisions of this Court and with other federal courts, the Court should grant certiorari and reverse the decision below.

The Supreme Court of Connecticut consolidated the *Hollis* and *Napoletano* cases for argument and decision. (App. 1a, 10a.) Its decision did not distinguish between the *Hollis* and *Napoletano* claims and offered the same rationale for finding all claims not preempted -- that is, that all respondents merely sought to enforce ERISA plans rather than dictate their terms, and that such claims are properly brought under state law. (App. 18a-19a, 34a-35a.) This rationale is in direct conflict with decisions of this Court and every federal appellate circuit -- all of which hold that causes of action by ERISA plan participants to enforce the terms of

their plan are exclusively governed by ERISA's civil enforcement provisions.

The first question presented in this petition -- whether state law claims brought by ERISA plan participants to enforce a plan are preempted -- is a question that this Court has answered definitively in favor of preemption in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 54 (1987), a decision followed faithfully by the federal courts ever since. Because the holding of the Supreme Court of Connecticut is directly contrary to this Court's holding in *Pilot Life*, the Court should grant certiorari and reverse the judgment of the court below on this issue. Similarly, to the extent that these claims rest on alleged misrepresentations of plan terms, certiorari is warranted because the claims of the *Hollis* respondents are plainly preempted, especially in light of this Court's decision in *Varity Corp. v. Howe*, 116 S. Ct. 1065 (1996), which recognized an exclusively federal cause of action to remedy misrepresentations about a plan.

The remaining question presented in this petition -- whether ERISA preempts state law causes of action for reinstatement asserted by physicians terminated from a network which provides services to ERISA plans -- has not been previously addressed by this Court and presents a split between the Supreme Court of Connecticut, as a state court of last resort, and federal appellate and district courts. Because of the national importance of the preemption question presented and the conflict and disarray among the

lower courts, the Court should grant the petition and hold the claims of the *Napoletano* respondents to be preempted.[3]

I. The Decision Below Regarding the *Hollis* Claims is Directly Contrary to Decisions of this Court and of Federal Courts of Appeal

The *Hollis* respondents are ERISA plan participants who seek to force their ERISA plans to cover the cost of health care benefits obtained from physicians who had been removed from petitioner's network. Respondents allege that access to these physicians had been promised to them through plan documents as well as through other representations made to them by petitioner, acting as plan administrator. (App. 5a-7a.)

In determining that respondents' claims did not sufficiently "relate to" an ERISA plan to trigger preemption, the court below recognized that the respondents were attempting to "enforce" rights granted under their employee benefit plans. (App. 34a-35a.) It is precisely this type of

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[3] Petitioner is aware that the Court currently has under review three cases that present questions involving aspects of ERISA preemption: *California Division of Labor Standards Enforcement v. Dillingham Construction N.A., Inc.* (No. 95-789), *cert. granted*, 116 S. Ct. 1415 (Apr. 15, 1996), *De Buono v. NYSA-ILA Medical and Dental Services Fund* (No. 95-1594), *cert. granted*, 117 S. Ct. 292 (Oct. 14, 1996), and *Boggs v. Boggs* (No. 96-79), *cert. granted*, 117 S. Ct. 379 (Nov. 1, 1996). Petitioner believes that the unique and important questions presented here deserve the Court's attention and will not likely be resolved by decisions in those cases.

claim, however -- a claim to "enforce" a plan according to its terms -- that Congress intended to preempt through the interaction of ERISA's civil enforcement provisions and ERISA's preemption clause.

The plain language of ERISA's civil enforcement section provides that a plan participant or beneficiary may bring a civil action, *inter alia*, "to enforce his rights under the terms of the plan." ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). As held by this Court, there is no question that the civil enforcement provisions of ERISA provide the exclusive mechanism to enforce rights granted to a participant through an employee benefit plan or through ERISA. *Pilot Life*, 481 U.S. at 54. In *Pilot Life*, this Court reviewed the enforcement provisions in § 502 as they relate to ERISA's preemption clause in § 514, which provides that ERISA's provisions "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This Court concluded unanimously that ERISA preempted, in favor of its own civil enforcement mechanism, the plaintiff's attempt to enforce his benefit plan rights through state law claims for breach of contract, breach of fiduciary duties and fraud:

> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive. This conclusion is fully confirmed by the legislative history of the civil enforcement provision.

481 U.S. at 54. *See also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990) (remedies under ERISA are exclusively enforced by § 502(a)).

Similarly, respondents' state law claims here "to enforce" employee benefit plans are preempted in accordance with ERISA's plain civil enforcement language, in conjunction with ERISA's preemption clause. In holding to the contrary, the decision of the Supreme Court of Connecticut is in direct conflict with decisions of this Court as well as of every federal court of appeals.[4]

Moreover, to the extent respondents' claims involve allegations of misrepresentations made by petitioner concerning benefits under ERISA plans, these claims are also preempted. Courts of appeal have uniformly held that state

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[4] *See Crull v. Gem Ins. Co.*, 58 F.3d 1386, 1391 n.3 (9th Cir. 1995) ("Claims to enforce the terms of an ERISA welfare benefit plan 'relate to' the plan, and are preempted under ERISA."); *Wolf v. Reliance Std. Life Ins. Co.*, 71 F.3d 444, 447 (1st Cir. 1995); *Anderson v. Humana Inc.*, 24 F.3d 889, 891 (7th Cir. 1994); *Alexander v. Electronic Data Sys. Corp.*, 13 F.3d 940, 943 (6th Cir. 1994); *Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148, 151 (2d Cir. 1994); *Brandon v. Travelers Ins. Co.*, 18 F.3d 1321, 1325 (5th Cir. 1994), *cert. denied*, 115 S. Ct. 732 (1995); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 764-65 (8th Cir. 1993); *Custer v. Pan Am. Life Ins. Co.*, 12 F.3d 410, 418 (4th Cir. 1993); *Winchester v. Prudential Ins. Co.*, 975 F.2d 1479, 1483 (10th Cir. 1992); *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1315 (3d Cir.), *cert. denied*, 501 U.S. 1232 (1991); *Foltz v. U.S. News & World Report, Inc.*, 865 F.2d 364, 371 (D.C. Cir.), *cert. denied*, 490 U.S. 1108 (1989); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1565 (11th Cir. 1987).

law claims seeking to remedy misrepresentations allegedly made by a plan administrator about a participant's rights under an ERISA plan "relate to" the plan, rejecting the argument that entitlement to the benefits arises not from the plan itself but from the separate promise of extra-contractual benefits made by the administrator.[5] These courts have reasoned that in order to determine whether the communication made to a participant was false, a court would be required to interpret the ERISA plan terms to ascertain the

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[5] *See Wilcott v. Matlack, Inc.*, 64 F.3d 1458, 1464 (10th Cir. 1995) (state law misrepresentation claim is preempted where "[d]efendants' alleged misrepresentations relate directly to the nature of plaintiff's rights under the plan"); *Variety Children's Hosp., Inc. v. Century Med. Health Plan, Inc.*, 57 F.3d 1040, 1042 (11th Cir. 1995) (misrepresentation claim preempted because it "center[s] on the issue of coverage under the plan"); *Carlo v. Reed Rolled Thread Die Co.*, 49 F.3d 790, 795 (1st Cir. 1995); *Howe v. Varity Corp.*, 36 F.3d 746, 754-55 (8th Cir. 1994), *aff'd*, 116 S. Ct. 1065 (1996); *Anderson v. Humana Inc.*, 24 F.3d 889, 891 (7th Cir. 1994) ("A claim that the literature distributed as part of a plan's administration is incorrect...lies comfortably within the zone of exclusive federal control"); *Hermann Hosp. v. MEBA Medical and Benefits Plan*, 959 F.2d 569, 578 (5th Cir. 1992) (state law misrepresentation claims are preempted when based on a plan's failure to pay benefits); *Smith v. Dunham-Bush Inc.*, 959 F.2d 6, 10 (2d Cir. 1992) (common law claims of negligent misrepresentation to enforce promise to pay pension-related benefits is preempted); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991), *cert. dismissed*, 505 U.S. 1233 (1992); *Berger v. Edgewater Steel Co.*, 911 F.2d 911, 923 (3d Cir. 1990), *cert. denied*, 499 U.S. 920 (1991); *Davidian v. Southern Cal. Meat Cutters Union*, 859 F.2d 134, 135 (9th Cir. 1988).

rights of the participant under the plan.[6] Such a claim must "relate to" the plan.

Any doubt as to whether such misrepresentation-based claims are preempted was put to rest by this Court's recent decision in *Varity Corp. v. Howe*, 116 S. Ct. 1065, 1076-79 (1996), which held that claims against a plan administrator alleging misrepresentations about plan benefits were actionable under ERISA § 502(a)(3). Because ERISA's civil enforcement provisions are exclusive, *Pilot Life*, 481 U.S. at 54, such a claim therefore cannot be maintained under state law.

The court below characterized the *Hollis* respondents' claims as based on misrepresentations about plan provisions. (App. 34a-35a.) Indeed, the court characterized these misrepresentations in the same way as this Court characterized the misrepresentations in *Varity* which it found to be actionable under ERISA. The *Varity* Court noted that the misrepresentations at issue concerned "detailed plan information [provided] in order to help [plan beneficiaries] decide whether to remain with the plan." 116 S. Ct. at 1067. Likewise, here reliance on the alleged misrepresentations (concerning participants' rights under their plans to continuity of care from a particular physician) was "[o]ne of the alleged reasons that the *Hollis* plaintiffs became or remained members of this plan." (App. 35a.) Therefore, just as the misrepresentation claims brought in *Varity* are encompassed

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[6] *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 139-40 ("the existence of a pension plan is a critical factor in establishing liability").

by ERISA's exclusive civil enforcement provision, *e.g.*, state a claim for breach of fiduciary duty pursuant to ERISA § 502(a)(3), so too are the claims at issue here.

II. The Decision Below Regarding the *Napoletano* Claims is in Direct Conflict with Decisions of Federal Courts

The *Napoletano* respondents are physicians who were terminated from petitioner's provider network and seek reinstatement to that network. Once reinstated, they would be authorized to seek reimbursement from their patients' (the *Hollis* respondents') ERISA plans for services provided to those patients. A similar claim, seeking an identical remedy, was held preempted by the Sixth Circuit in *Zuniga v. Blue Cross and Blue Shield of Michigan*, 52 F.3d 1395 (6th Cir. 1995), creating a direct conflict in authority between a state court of last resort and a federal court of appeals.

The plaintiff in *Zuniga* was a psychiatrist terminated from a provider network administered by Blue Cross, through which he had provided health care to ERISA plan participants. He alleged that Blue Cross had violated various state and federal laws and had breached a settlement agreement in terminating him from the network and sought an injunction requiring reinstatement. The Sixth Circuit held that the plaintiff's state law breach of contract claim (the only claim at issue on appeal) involved the "reason for denial of his application to be an authorized provider for the [ERISA plan]," and thus clearly related to the plan.

> It is not the label placed on a state law claim that determines whether it is preempted, but whether

> in essence such a claim is for the recovery of an ERISA plan benefit. That is exactly what Zuniga seeks here, the payment of benefits under the plan for his treatment of covered patients....Further, ERISA's civil enforcement provision clearly provides this type of remedy. Although this remedy is not available to Zuniga, that does not mean that no remedy exists.

52 F.3d at 1401 (citations omitted).

A similar conclusion was reached in *Adnan Varol, M.D., P.C. v. Blue Cross and Blue Shield of Michigan*, 708 F. Supp. 826 (E.D. Mich. 1989). Plaintiffs in *Adnan Varol* were participating physicians in defendant's network through which they provided services to ERISA plan participants. They alleged that the conditions of their participation in the network violated various state statutory and common laws. The court found that the state law claims "related to" the plan within the meaning of § 514, stating that

> [w]hile it may appear that this case represents a fight between plaintiffs and [Blue Cross], two parties who are not related directly to the employee-benefit plan, this is only superficially true. It is only because the Plan and its provider agreements require these parties to be in contract....[T]he fact is that [Blue Cross] is acting as the administrator of the Plan and the provider contracts...are merely the means for carrying out the benefit Plan.

708 F. Supp. at 832.[7]

As in *Zuniga*, "the relief [respondents] seek is to be reinstated as a preferred provider, which means being paid under the terms of the plans for [their] treatment of covered patients." 52 F.3d at 1402. Therefore, the *Napoletano* respondents' claim of entitlement to continued participation in the provider network unquestionably "relates to" the employee benefit plans that use that network and should be preempted.

III. The Decision Below Presents Substantial Questions of National Significance

Resolution of the questions presented is urgently needed because of their impact on health care benefits received by the majority of American workers and their families. An estimated 114 million Americans receive health care benefits through employee welfare benefit plans subject to ERISA.[8] So prevalent has the use of provider networks

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[7] *See also Stewart v. Stearman*, 743 F. Supp. 793, 796 (D. Utah 1990) (because provider agreement was an integral part of the employee benefit plan, ERISA's remedial provisions governed any dispute concerning this relationship); *Blue Cross and Blue Shield of Ala. v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258, 1267 (N.D. Ala. 1983) (same).

[8] *See* U.S. General Accounting Office, Health, Education, and Human Services Div., *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA* (GAO/HEHS-95-167) (1995) ("1995 GAO Report") at 2, 45. *See also* Employee Benefit Research Institute Education and Research Fund, *EBRI Databook*

become in these plans that recent government statistics show that they are available to upwards of 90 million persons who are participants or beneficiaries in ERISA welfare plans,[9] and over 70 million individuals are enrolled in network-based managed care through employer-provided insurance.[10]

Concurrent with the expansion of provider networks in the delivery of health care benefits to ERISA plan participants has been a rise in the number of law suits challenging the administration of these networks. Because the majority of Americans that receive health care benefits do so under ERISA-covered employee benefit plans, most of the suits asserting state law causes of action have involved questions of ERISA preemption. As this Court noted as early as 1981, defining the boundaries of this preemption is not an easy task. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). The preemption analyses of lower courts have continued to diverge despite this Court's efforts to provide consistency.

In reaching its conclusion in this case, the court below extensively discussed this Court's *Travelers* decision, characterizing it as having indicated a "retreat[ ]" from this Court's previous "expansive view" of preemption. (App.

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on Employee Benefits (3d ed. 1995) at Table 8.8.

[9] *See* U.S. General Accounting Office, Human Resources Div., *Managed Health Care: Effect on Employers' Costs Difficult to Measure* (GAO/HRD-94-3) (1993) at 5-7.

[10] *See* 1995 GAO Report at 20 n.39.

27a.) Citing post-*Travelers* authority from federal courts of appeal, the court reasoned that "[a]lthough a successful claim under [the Connecticut statute] would in effect require that CIGNA continue to employ the plaintiff physicians, such a result would not have an impermissible or burdensome effect on the administration of the plan." (App. 39a.) In short, the court below concluded that *Travelers* has sufficiently changed the preemption landscape that it is now permissible for a state to regulate a plan's administration as long as that regulation is not, in a court's view, "burdensome."[11]

In contrast, other appellate courts discussing *Travelers* have properly recognized that its holding was limited to those state laws that have only an indirect, economic burden on plans. As the Ninth Circuit has recently said:

> *Travelers Insurance* may well signal the present Justices' unhappiness with the rather sweeping deregulatory effect that an expansive reading of the words 'relate to' has had. It does not, however, signal a retreat from *Pilot Life's* holding that the civil enforcement provisions of ERISA § 502(a) were intended by Congress to be exclusive. Claims to enforce the terms of an

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[11] At least one federal appellate court has interpreted *Travelers*, as did the court below, as representing a sea change in this Court's preemption jurisprudence. In *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1466-67 (1996), the Fourth Circuit found common law claims for malpractice against a plan administrator not preempted "[i]n light of the Supreme Court's recent (and narrowing) interpretation of the scope of ERISA preemption in [*Travelers*]."

> employee welfare benefit plan 'relate to' the plan, and are preempted under ERISA.

Crull v. Gem Ins. Co., 58 F.3d 1386, 1391 n.3 (9th Cir. 1995). Similarly, the District of Columbia Circuit recently observed that "[a]lthough the *Travelers* Court cabined ERISA preemption in that one aspect [indirect economic influence], it also carefully reiterated its prior position that 'state laws providing alternative enforcement mechanisms...relate to ERISA plans, triggering preemption.'" *Board of Trustees of the Hotel and Restaurant Employees Local 25 v. Madison Hotel, Inc.*, 97 F.3d 1479, 1486 n.13 (D.C. Cir. 1996), quoting *Travelers*, 115 S. Ct. at 1678.[12]

This split in the circuits in interpreting the scope and meaning of *Travelers* goes beyond their disagreement over whether *Travelers* was intended by this Court to "indicate[] a retreat from preemption." Rather, they squarely conflict over whether, after *Travelers*, state law, including claims based on state law, may directly regulate plan administration. The two analyses cannot be reconciled.

Also paralleling the growth in the provision of network-based managed care to ERISA plan participants has been the proliferation of state legislation regulating the

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[12] *See also CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 649 (5th Cir.) (emphasizing the "limited nature of [*Travelers*'] holding"), *cert. denied*, 117 S. Ct. 387 (1996); *McFarland v. Union Cent. Life Ins. Co.*, 907 F. Supp. 1153, 1159 (E.D. Tenn. 1995) (expressly rejecting plaintiff's argument that *Travelers* "pull[ed] back from an unending expansion of federal jurisdiction" and instead held that *Travelers* "expressly reaffirmed prior authority").

contracting practices of networks with their member providers. Some 25 states have enacted "any willing provider" laws which prohibit a network from selectively contracting with providers at all.[13] Other states regulate a network's contracting practices by, for example, prohibiting "without cause" terminations or requiring that the network's provider agreements include specific terms or conditions.[14] States continue to enact such laws,[15] and both states and private parties continue to bring suit to enforce laws already on the

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[13] *See* Ala. Code § 27-45-3 (Supp. 1994); Ark. Code Ann. § 23-79-114(b) (Michie Supp. 1993); Conn. Gen. Stat. Ann. § 38a-471 (West 1982); Del. Code Ann. tit. 18, § 7301 (Supp. 1994); Fla. Stat. Ann. § 408.706 (West Supp. 1995); Ga. Code Ann. §§ 33-20-16 (1976); Idaho Code § 41-3937 (Supp. 1995); 215 Ill. Comp. Stat. Ann. 5/370h (West 1993); Ind. Code Ann. § 27-8-11-3(b)-(c) (Michie 1994); Ky. Rev. Stat. Ann. § 304.17A-110 (Banks-Baldwin Supp. 1994); 1994 Mass. Acts 60, §§ 148-49, 241; 1994 Minn. Laws 2927; Miss. Code Ann. § 41-83-3 (1994); N.H. Rev. Stat. Ann. § 420-B:12(V) (Supp. 1994); 1994 N.J. Laws SB 886/AB 1221; N.C. Gen. Stat. § 58-51-37 (1994); N.D. Cent. Code § 38.2-4209(B)-(D) (1994); Ohio Rev. Code Ann. § 1742.09(B)(2) (Anderson 1996); Okla. Stat. Ann. tit. 36, § 3634 (West Supp. 1994-95); S.D. Codified Laws § 58-18-37 (Michie 1990); Tex. Ins. Code Ann. art. 20A-14(g)(h) (West 1996); Utah Code Ann. § 31A-22-617 (1991); Va. Code Ann. § 38.2-3407 (Michie Supp. 1996); Wis. Stat. Ann. § 628.36 (West 1995); Wyo. Stat. Ann. § 26-22-503(a)(1) (Michie Supp. 1995).

[14] *See* Group Health Ass'n of America, *State Managed Care Legislative Resource* (1996) (listing statutes).

[15] *Id.*

books.[16] The fact that the Connecticut Managed Care Act is one of many such statutes underscores the nationwide scope of the clash between ERISA's protection of the freedom of employee benefit plans to structure their own benefit programs and many states' efforts to restrict that freedom.

For these reasons, ERISA's goal of promoting uniform national regulation of plans, *Travelers*, 115 S. Ct. at 1677-78, has remained particularly elusive with respect to plans' utilization of provider networks. Unless the preemption questions presented here are resolved by this Court, employee benefit plans will be faced with the prospect of either litigating over preemption in multiple jurisdictions or simply foregoing implementation of provider networks, especially on a uniform nationwide basis. Absent review by this Court, litigation over ERISA preemption and laws regulating network administration will only increase, and the conflicts among the lower courts will likely only deepen.[17]

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[16] *See, e.g., American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc. and Prudential Ins. Co. of Am.*, No. 96-10084-MEL (D. Mass. filed Jan. 17, 1996) (suit by pharmacies alleging violation of Massachusetts any willing pharmacy law).

[17] Legal commentators have also noted the unanswered nature of the question presented here. *See, e.g.*, Richard C. Reuben, *In Pursuit of Health*, 82 A.B.A. J. 54, 56 (October 1996) ("Most experts say the U.S. Supreme Court will utlimately have to decide the scope of ERISA pre-emption in the HMO context to establish uniform rules."); Jesselyn A. Brown, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 Yale L. & Pol'y Rev. 339, 380-81 (1995) (discussing uncertainties regarding preemption of state managed care legislation); Gary A. Francesconi, *ERISA*

Accordingly, petitioner urges the Court to grant certiorari on the questions presented in this petition.

CONCLUSION

For the foregoing reasons, the Court should grant the petition for a writ of certiorari on the questions presented.

Preemption of "Any Willing Provider" Laws -- An Essential Step Toward National Health Care Reform, 73 Wash. U. L.Q. 227 (1995) (same).

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